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ABSTRACT

This ethnographic study sought to understand, from the native perspective, the traditional childbearing values and practices of Coast Salish peoples and the difficulties in maintaining these in a society that is not oriented to native values and practices. Observations and interviews were carried out over a 4-year period on the Songhees reserve in British Columbia, with the most intensive research focused on six women of childbearing age and four women of post-childbearing age and their families. A review of the literature and analysis of research data generated a conceptual framework that integrated mind, body, spirit, and environment concepts and focused on transactional processes. The Medicine Wheel is the native means of structuring the integration of these concepts, with its four directions depicting concepts essential to wholeness and health. During any part of the life cycle, health is related to harmony among the elements of the individual's Medicine Wheel and all others in the individual's environment. Family members and elders are responsible for the general education of youth, but women are primarily responsible for health matters and transmission of childbearing beliefs and practices. Health and childbearing education are accomplished as a part of daily life and at salient times through oral communication and role modeling. Women who had received traditional childbearing teachings felt committed to them and did not perceive contemporary health care workers as part of their health care system. Prenatal classes were perceived as being "difficult" since they are not taught in traditional ways. This paper contains 19 references and 4 diagrams of Medicine Wheel concepts. (SV)

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INTRODUCTION

"FROM WHOSE PERSPECTIVE?"

Children are one third of our population and all our future ...their health is our future. Regardless of cultural heritage, traditional wisdom, or contemporary practices, the significance of a healthy pregnancy to the health and well-being of our children is recognized universally. The childbearing period may be likened to a launching pad - it is the springboard to the future.

Health practitioners state that there is a lack of prenatal care - that native women do not solicit or attend early and regular prenatal care. However, that may be the situation from only one perspective: a non-native one. Health care providers and their Native clients may have differing explanatory models of health during pregnancy. Types of sources of knowledge about health and pregnancy may differ, or even conflict. "These differences will be reflected in discrepant expectations and miscommunication which may result in avoidance of perinatal health care" (Farkas,

et al, 1989). It is important to note, however, that there has been little research conducted on perception or explanatory model differences of health during pregnancy between client and practitioner. Little is known about the important beliefs and attitudes of native women and their families that direct their practices during this critical stage in their life cycle.

Understanding a situation from another person's perspective is not only a difficult task, it is also threatening. Differences between perspectives often get interpreted as either wrong or right, engender feelings of either guilt or omnipotence, or result in either anger or frustration. This misunderstanding leads to splitting apart rather than drawing together - isolation, based on prejudice rather than integration based on understanding. Integration is defined as the "unification of diverse elements into a complex whole or a harmonious relation" (Living Webster,1977). Integration implies harmony. In health care it means making services available, appropriate, and acceptable to members of all races, religions and ethnic groups. Clearly, if health care is to be culturally appropriate and effective and health outcomes improved, perspectives of health care workers and clients must be integrated.

In British Columbia, Native Peoples experience an unwarranted number of adverse pregnancy and infant outcomes, have the poorest level of health and experience discrimination problems within the existing health services (Report of the Community Health Centre

Project, 1972). For instance, reports and studies have noted an increasing incidence of children with Fetal Alcohol Syndrome, with a disproportionate number born to native women (Asante, 1981; Smith, 1981: Macleod, 1983). Adverse pregnancy outcomes, such as FAS, occur as a result of the interaction of lifestyle, family environment, human biology and health care delivery system (Lalonde, 1974).

THE STUDY

"A CULTURAL LESSON"

Purpose of the Study

The purpose of the ethnographic study was to understand from the native peoples' perspectives their traditional native childbearing values and practices, the difficulties encountered in maintaining these in a non-native oriented society, and the problems these difficulties cause in family life.

The Setting

The study was carried out on the Songhees reserve. The Songhees band members belong to the Coast Salish tribe, one of three tribes living on Vancouver Island, British Columbia. Their reserve is located just west of Victoria. The Coast Salish people live primarily on the southeast portion of Vancouver Island and the south-west coast of the mainland of British Columbia, Canada and the state of Washington, United States of America (Map 1). Because the Coast Salish occupy such a diversified environment, they have acquired a unique variety of cultural traits and social

organization based on a patrilineal hunting, fishing and gathering system.

Review of the Literature

Before embarking on the ethnographic research, an intensive literature search was done. The purpose was to understand as much as possible the rich history of the Coast Salish peoples and learn about their traditional and contemporary perspectives and experiences with health, their environment, and health care systems.

Lifestyle

The Coast Salish of B.C. have traditionally spent much time and activity in promoting wellness and preventing and curing illness (Amoss, 1972). Health is considered a state of balance with nature and the supernaturals. Harmony among the spiritual, emotional and physical self functions prominently in health concerns (Amoss, 1972).

At particular stages in their life cycle, both males and females are required to adhere to, and to practice, "disciplines" and rituals in order to increase their strength and health: bathing in cold water, being isolated from the rest of the band, rising early and keeping busy with appropriate responsibilities. Puberty has been a time demanding strict adherence to these disciplines. Girls were required to give up the "ways of the boys", learn the skills of womanhood for roles of wife and

mother, become familiar with herbs and medicines required to maintain wellness or cure illness, and seek their spiritual power through a vision quest (Attneave, 1979).

Childbearing, like puberty, has been viewed as a natural transition event: a state of health, but requiring special observances or rituals. The underlying concept was that, during this time of change, the mother was in a peculiar condition of ritual uncleanliness, but simultaneously imbued with magical powers capable of causing good or harm. The Coast Salish also believe that a mother begins to give care to her baby during pregnancy. Therefore, it is important to observe customs that keep evil spirits away and encourage the presence of good spirits that might protect and help during the childbearing period (Drucker, 1965).

After birth, the father as well as the mother was in a vulnerable state requiring seclusion and dietary restriction (Drucker, 1965; Bushnell, 1981). This seclusion was terminated by ritual bathing directed by the family to cleanse and fortify the parents with purity (Barnett,1939; Drucker, 1965). Other cleansing ceremonies were in the form of songs, dances, or pantomimes that taught new or altered roles during the life event.

Human Biology

Human biological factors may alter individuals' (mothers' and fetus') susceptibility to adverse effects of an unhealthy

lifestyle, or their vulnerability to environments (Clarke & Driever, 1983). Very few studies were found, however, that addressed the issue of biological factors in native health. One study by Macleod (1983) suggests that the high incidence of FAS noted among native people may be linked more to parental genetics than to the amount of alcohol consumed.

Environment

Environments are extremely important to the Coast Salish. The family network, a microcosm of native society, is for the individual the immediate environment. The family environment transmits values, beliefs and practices to its members. Expectations regarding lifestyle practices, such as drinking, are clearlyfamily related. The family provides the supportive or nonsupportive sociocultural environment for carrying out daily activities in culturally appropriate ways.

Behavior patterns associated with childbearing are subject to family network influences. Many native families utilize the extended family to teach the young people family responsibilities, cultural values, and personal skills. Hungry Wolf (1982) wrote:

> My grandmothers didn't usually learn about childbirth until they were ready to have their first children. I was raised this way too, and it is one of the things about our customs

> that I have never understood.... If it was a first pregnancy then the mother-to-be was given advice by an older woman with more experience, often a sister-in-law or the mother-in-law (Hungry Wolf,1982:190).

Teaching of values and beliefs occurred in a variety of mediums: myths, legends, stories, vision quests, disciplines, old wives' tales, games and sports, and even dancing. Transmission of knowledge and understanding "...flowed gently through the family unit. There were no terms to define this progression. It was just plain everyday living" (Vincent, 1984).

Health Care Organization

Entrance into the non-native health care system has been viewed by Coast Salish People as being appropriate only when illness is present or when there is an irregular component to the process of pregnancy. Dissonance between traditional and contemporary beliefs and customs may inactivate health seeking behaviors in the non-native health care system and discourage adherence to contemporary advice that is inconsistent with traditional values. It is important to understand that use of a contemporary health care delivery system rarely totally suppresses traditional practices, but rather provides a source of additional alternatives.

In summary, the Coast Salish people have had a strong and specific orientation to childbearing. Pregnancy has been considered an important, but normal stage, of the woman's life cycle. Beliefs and practices that promote healthy pregnancies have been transmitted over many generations. They have provided direction for the woman and her family with respect to lifestyle, interactions with the environment, and use of health care systems. Many native peoples stress the importance of respect and knowledge of their cultural norms as being a valuable asset for any health care person working with them. To many this is more important than knowledge and technical skills (Horn, 1975).

Design

The Three Stages

The research study developed in three stages over a four-year period, 1980-1984. The first stage was the Initial Entry into the cultural milieu: establishing trusting relationships with native leaders and health care workers who gave advice and guidance in determining the most appropriate study methods. Mentors and culture brokers, a Community Health Representative (CHR), and Native Drug and Alcohol Program consultants made Stage Two possible.

Stage Two, Reserve Contact, involved getting permission first from the Band Chief and Council to engage in the study on the reserve and then from the women and their families to carry out the interviews.

The third stage, Confirming the Study, was undertaken to estimate the degree of reliability and validity of the data and to determine similarities and differences of the Songhees Band with other Coast Salish and Northwest Coast Tribes. Both formal and informal contacts were developed with Band members and CHR's of the four Saanich bands at potlatches, canoe races, health fairs, pow wows and workshops. Preliminary comparison of Coast Salish findings with those of other Northwest Coast tribes was made possible through a six-week volunteer work experience in a residential alcohol treatment centre for Native families of the Northwest Coast.

Methods

This ethnographic study used the following methods of data collection: intensive and extensive interviews, event analysis, participant observation, and unobtrusive measures. During the year of data collection, the researcher talked with elders, childbearing women, and family members and attended potlatches, canoe races, pow-wows and family dinners. Band counselors and office staff answered numerous questions and requests.

The most intensive and indepth research was carried out with six women of childbearing age and four women of post-childbearing age and their families. The intent was to explore the fullest range of childbearing beliefs, values and teachings with women and their families who had had children but were in different stages

of their life cycle. Formal participation with the women included interviews and the administration of two instruments: an Ethnic Identity Scale (EIS) and Self Esteem Scale (SES).

The qualitative data were analyzed using a combination of the constant comparative method (Glasser & Strauss, 1967) and developmental research sequence (Spradley, 1979). The quantitative data were subjected to measures of central tendency and t-tests. This chapter reports primarily on analysis of the qualitative data.

THE RESULTS

"THERE'S A LOT TO LEARN"

Medicine Wheels and Transactions

Based on the review of the literature and analysis of the research data, a basic conceptual framework was developed which integrated mind-body-spirit-environment concepts and focused on transactional processes. These processes are defined as integrative responses of individuals and families to the changing demands of daily living, within their present cultural context.

The Medicine Wheel, a traditional way of interpreting health, is the native way of structuring the integration of the mind-body-spirit-environment concepts (Storm, 1972). It is as meaningful to native peoples today as it was to their great grandparents.

The four directions of the Medicine Wheel depict the concepts essential to wholeness and health (Figure 1 "Medicine Wheel: Directions of Understanding").

Figure 2 "Integrated Medicine Wheels" illustrates the inter-relatedness of the various levels of the Medicine Wheel and the transactional processes that integrate them. The individual is considered to be a Medicine Wheel within a larger family one. At the inner core of the individual's Medicine Wheel is the self-concept, which is influenced by every aspect of the lifecycle and environment. The family medicine wheel reflects its functions as provider, supporter, mediator and facilitator. The transactional process of education occurs between the family's and individual's medicine wheels and is instrumental in integrating the two. The greater, more complex Band environment is also considered a Medicine Wheel. It includes cultural values and beliefs which can only be understood within the context of historical and contemporary milieu. Ethnic identity is the continuous transactional process that occurs between the Band and family to promote feelings of nativeness and solidarity.

During any part of the lifecycle (e.g. childbearing - figures 3 and 4), health and wellness are experienced when there is a harmony between the individual and all other Medicine Wheels comprising the individual's environment and when there is a balance among the elements of any of the Medicine Wheels. The directions of the Medicine Wheel and the characteristics of each

provided the framework for categorizing the health and childbearing values, beliefs, practices, and teachings. The transactional processes were conceptualized from analyzing the dynamic aspects of the data. They explain, in part, the differences which occur among and between individuals, families and bands.

Family Environments

A typology of Family Environments emerged from this study. Consistent with the four directions of the Medicine Wheel and the education transactional process, the family performs four major roles or functions as the environment for its members. These roles are provider, supporter, mediator and facilitator.

The north physical direction of the Medicine Wheel reflects the native family's role as provider. The family provides a physical environment which contributes to the individual member's health and sense of well-being. The home, family membership, childrearing responsibilities and instrumental and material aid were identified as contributing significantly to carrying out the provider functions well.

The east direction reflects the supporter role. The family offers varying degrees of support to its members for carrying out health-related behaviors and for developing a sense of well-being and emotional health. Support is given through the teachings about the maternal-fetal relationship and through love.

The south, socio-cultural direction of the family's Medicine Wheel can be compared to its role as mediator between family members and the community. The family is the culture-broker, transmitting beliefs and values important in giving direction to acceptable native behavior. As mediator, the family has the potential of developing positive family relationships, ethnic identity, and self-concepts. The most important social relationships to the Songhees peoples were the family relationships. The role of grandparents was particularly important for the transmission of cultural values. The positive factors tended to be associated with family cohesiveness, feelings of belonging, and mutual support. Extended family relationships, which included young children and elders, were viewed as critical to positive, healthy outcomes for the family. Disjunctive family relationships, such as those influenced by heavy alcohol consumption, were associated with a negative aspect of mediation.

Family spirituality of the west is a major facilitating factor in family health and the well-being of its members. Sharing values, practices and disciplines, as well as participating in native ways such as healing ceremonies and vision quests facilitates the member's potential for developing her own spirit and power. Specific family teachings and traditions that make this possible are sacred to the family.

The total family environment is described as being both supportive and non-supportive during childbearing. Factors in the physical environment that are supportive are living on the reserve and receiving both instrumental and material aid from the family as needed. A supportive, positive emotional environment was described as one in which there is encouragement to do the right thing, an understanding of what the woman is experiencing, an interest in the baby from the time of confirmation of the pregnancy, and an ability to teach at the time of the event - or when the need arises. The supportive, positive socio-cultural factors of the family environment include caring, cohesiveness, and role-modeling. Not being part of the family or not having a sense of belonging were issues that created anxiety for women (e.g.moving to their husbands' reserve and sometimes into the husbands' family home). Lack of knowledge of family relationships, traditions, and Band beliefs and values was initially very upsetting.

Education for Childbearing

The importance of education to the Coast Salish people is explained by an elder as "Teaching and learning - it is a way of life for our people - it is experience and listening to the wisdom of our parents and their ideas." Although family members, especially grandparents, and elders are considered to be primarily responsible for the general education of the youth, when it came to health matters, women are primarily responsible. They are traditionally the general family health carers. Women

provide for health, carrying out the basic domestic activities associated with the maintenance of a home. They teach about health and nurse the sick; they mediate with outsiders and cope with crises. They play a critical role in health and the transmission of beliefs and practices of childbearing.

Teaching about health is a responsibility which is accomplished, intentionally or unintentionally, as part of daily life. Looking after yourself and looking after children involves teaching by example. In providing for family health or in treating family illness, parents, and mothers in particular, are inevitably working as health educators. However, if the woman had experienced a negative relationship with her mother or mother-in-law she was often hesitant to take an active role in teaching her daughter. Reasons for this included lack of sufficient knowledge of the native ways, questions of validity of these teachings, a desire to spare her daughter the rigors of the practices, and concern about making decisions for her daughter and interfering in her life.

In general, all band members have some responsibility in the educational process. The planning of teaching is perceived as the responsibility of family, imparting wisdom the responsibility of elders, listening the responsibility of the child or other family member, and monitoring adherence to the teachings the responsibility of the community. It is apparent, however, that the transmission of the traditional teachings, interrupted by

residential school attendance, has not been adequately reinstated. The availability of elders and grandparents is of grave concern. They are dying before their wisdom and teachings have been tapped.

Teachings of Childbearing

The research revealed that there were two major teaching methods: oral communication and role modeling. Education is not "book learning"; it is the stories, legends, and lectures about the teachings and disciplines told over and over again.

Learning is believed to occur in two general ways. Primarily one is expected to learn from the teachings and experiences that one receives. The second way might be labelled "common sense" or wisdom. It is expected that if an individual gets in to a particular situation, such as pregnancy, that she will have the common sense or wisdom to know what to do, or else she would not be in that situation.

Timing of education is salient. "Teaching cannot be turned on just like that - parents, grandparents and elders teach you when it is time" explained a grandmother. Thus, one has to be there, not just physically, but mentally has well. It is, in part, the individual's responsibility to be in the right place at the right time, as there are no structured classes, nor predetermined times of teaching.

The goal of education was defined as being able to live like your mother, father, or esteemed relative whose name you might share. "Thank you for behaving like _____" was a compliment to the family, since it signified that they had taught their member well.

Education is considered a way of life from conception to death. "The first day of conception is the first day of training". It is believed that one starts to learn before birth, and what the mother does, sees, feels, and learns influences not only the fetus, but the child's later life. Learning continues through all stages of the Circle of Life. It is never ending. As one parent expressed it "I cannot teach you everything now - I would need four seasons to teach the disciplines, and then there are always the lectures - like at marriages and in the Longhouse".

Each of the identified Medicine Wheel teachings was analyzed according to eight theoretical properties of the educational process.

1. The degree of commitment they to the teaching
2. The source of the teaching
3. Timing of the teachings
4. Expected recipient of adherences to the teaching
5. The teaching method
6. Type of message
7. Readiness to learn
8. Readiness to teach.

Of particular importance to the childbearing women were the commitment to the teachings, sources of the teachings and knowledge, and timing of the teachings.

Women who received traditional childbearing teachings felt, on the whole, committed to them - either in their own practice or those of their daughters. There appears to be a relationship between the level of commitment reported and the degree of ethnic identity felt by the woman. However, the degree of commitment also differed depending upon the subject or content of the teachings. Highest commitment was to the emotional state teachings, while the lowest was to activity and rest in the physical direction. Yet, when asked what they would change in a future pregnancy, most childbearing aged women stated that they would adhere more closely to the teachings about activity. The most frequent recipient, or person affected by the outcome, was the pregnant woman, but the baby, child and adult self were also identified by all women.

Many women who demonstrated low commitment to traditional teachings reported feelings of conflict in finding out and/or carrying out native teachings. Other parents said that they lacked sufficient knowledge of native ways. Thus, they stated, reliance was now put on individual common sense or wisdom.

The primary source of teachings was the mother, while grandmothers were the second most frequently named source.

Proximity at the time of the first pregnancy seemed to be the deciding factor as to who would be the teacher. Generally, post-childbearing women indicated that their source of contemporary knowledge was gained through experience. For the childbearing women, sisters and their own experiences were the third most frequent sources of knowledge. No teachings were directly attributed to a health care professional.

The majority of childbearing-specific teaching occurred at the time of the event, or when the need arose. Almost all of the women stated that the traditional teachings, while directing behavior, in no way prepared them for the physical, emotional, social, and cultural changes they would experience. The women indicated a desire to understand these changes, but did not see the non-native community resources as a means to do this.

On a more general level, almost all the women in this study told about the strength and support of their mothers as being vital to the development of their own inner strength. Their mother served as a role model as she demonstrated her strength and tenacity, especially in dealing with everyday hardships of native life and sometimes with abusive relationships that often accompanied family drinking.

The Childbearing Woman's Medicine Wheel

What were the women taught and what did they learn? The content of the health and childbearing teachings were analyzed and

categorized according to the meanings of the directions of the Medicine Wheel - physical, emotional, socio-cultural and spiritual. In all directions of the Medicine Wheel there were specific traditional teachings being transmitted intentionally or unintentionally to the childbearing woman. Analysis of the teachings did not find any of the teachings detrimental to the health of the mother or fetus. However, teachings that required "no change" might be considered questionable if they deter women from seeking early and continuous prenatal care. Many times the exact mechanism of action of the resulting practice was unknown. For example, native women related stories about the influence of the mother's sensory experiences on the fetus, but little is known as to the mechanisms contributing to the responses or outcomes.

North: Power of Wisdom - Building Physical Health

Elements contributing to the physical aspect of the women's Medicine Wheel related to diet and nutrition, activity and rest, labour and delivery, and breastfeeding. The women recounted teachings about these that were almost exclusively of a traditional nature. Those that were not were suggested to have emanated from one's self - one's intuition.

The childbearing teachings of diet and nutrition were the most numerous and frequently mentioned. There was a tendency to a high level of commitment, and very few women were skeptical of the teachings. Most of the traditional teachings admonished the

restriction of certain foods such as berries, seafood, organ meats, and fatty and heavy foods. The reasons for teaching the practice varied, as did the anticipated outcomes. For instance, one should not eat crab while pregnant because of all the legs:

- the baby might be born with seven toes and fingers
- it will make the baby soft, with soft bones
- the baby will have bow legs
- the labour will be hard
- the baby may grow up with a "crampy" stomach
- the baby will be a biter when nursing.

Fewer teachings were recounted for activity and rest. The level of commitment was only medium and few women practiced the teachings themselves. The mother and the baby were the primary recipient of expected outcomes. Modifications, rather than new behaviors were required, and additions rather than restrictions, were taught. Activities of daily living were encouraged so that women kept active, walked, did usual housework, or worked in the fields. Inactivity could cause:

- the baby to have a hard time during labour
- the woman to have a hard, long, and dry labour and a large baby
- the baby to be unhealthy and lazy
- the baby to be stuck to one part of the body and womb.

East: The Power of Illumination - Strengthening Emotional Health

Emotional support and a positive mother-fetus relationship were the major elements of this direction of the Medicine Wheel. Most of the teachings related to thoughts about the fetus and one's state of personal feelings. It is believed that the ability to conceive and the emotional and physical well-being of the fetus are influenced by whether or not one wants to be pregnant. Sensory experiences of the mother (e.g. sight, sound, and taste) are considered to be passed on to the fetus as the link between mother and fetus is very strong. Commitment to these Medicine Wheel teachings of emotional health were particularly high. Women are protected from frightening events and sights, including pictures; they are instructed on developing good feelings for the fetus; and an effort is made to communicate through voice, music, sights, and events with the fetus. None of the women who knew the native teachings thought that they were superstitions, old wives' tales, or that they conflicted with other values or teachings.

South: The Power of Innocence and Trust: Encouraging Socio-cultural Health

Health beliefs and practices, teaching about menarche, and learning about lifestyle behaviors such as smoking and drinking were elements of the childbearing woman's Medicine Wheel. Teachings about lifestyle beliefs, values, and practices that related to being a woman began at or before puberty and carried on throughout the Circle of Life. There is an acknowledged belief

that if on "listens" to one's body, one would learn what was beneficial or harmful to one's health or that of the fetus. Thus, during pregnancy, the body is likely to indicate that smoking and drinking alcohol are not good or that rough, contact sports are dangerous after a certain stage of pregnancy. Several women spoke of a change in desire for, or tolerance of, alcohol and thus restricted their intake.

West: The Power of Introspection - Spiritual Fulfillment

The elements of inner spirit, sources of strength, and relationships with the fetus were found to be important to spiritual well-beingof the mother and fetus. A respected and loved elder summed up this element of health.

> In life there are four directions - from each direction there is a strength. It is the personal and family involvement, really caring for one another's well-being, that has kept our people strong and unified. Spirituality comes from within, within your heart. I makes you happy. It's where your strength lies.

Coast Salish people believe that everyone is born with an inner spirit, a power. It is fostered through good parenting, adherence to disciplines at critical stages of the Circle of Life, and involvement in cultural activities such as spirit quests, initiation, and work in the Longhouse and Shaker church ceremonies. This inner spirit has the ability to make the person strong and to prevent illness.

SUMMARY

A MATTER OF QUESTIONS

In the past, residential school education discouraged native cultural ways. Much of the past tradition which was lost is now being rekindled and sought after. These efforts have become means of sustaining a native identity. The past and present native teachings rely almost exclusively on an oral tradition of communication, and to some extent observation of role models. The informal mode of teaching is seen as appropriate to developing the native way of life. Specific, more formal teaching takes place at the time of the event, when it is time to learn. For the native childbearing women today, occasions to learn about the general native way of life are being sought. There is a paucity of written material by, or about, Coast Salish peoples to help with this.

Grandmothers of childbearing women have had the opportunity of learning from their parents, whereas their daughters were denied this privilege. The mothers of childbearing women did not grow up with the traditional teachings and language, nor did they receive non-native teachings about childbearing in residential schools. Today's childbearing women have knowledge of only some traditional teachings and a few contemporary ones. They are unsure sometimes of the relevancy of the traditional teachings to the non-native health care system's expectations, yet are distrustful of contemporary teachings.

The native women in this study did not perceive nurses, or other contemporary health care workers, as part of their health care system. Nor did they see others as being knowledgeable about their practices. They wanted to learn from each other and re-establish some of their native beliefs and practices. Prenatal classes, and educational programs in general, were perceived as being "difficult": not because the women do not want to learn or the elders do not want to teach, but because traditionally teaching takes place in traditional ways, as well as at appropriate times.

Although the findings from this study cannot be generalized, even to the Coast Salish people of British Columbia, a number of questions need to be asked. These include:

1. How can prenatal, and other family health, programs be developed to integrate the effective beliefs and practices from both traditional and contemporary cultural perspectives?
2. How can health professionals be sensitized to the cultural beliefs, practices, and needs of native childbearing women and their families?
3. What are the most effective ways for native peoples to teach their traditional ways to assist childbearing women and their families promote and maintain health and to live harmoniously with a non-native health care system and way of life?

4. When can the unique communication channels (e.g. dinners, tribal fairs, ceremonies) that exist on reserves be used for conveying certain health messages?

The major dilemma experienced by the native women can be summed up as the challenge of learning to be native and feeling good about it. If health care workers are to be instrumental in improving the well-being of native families and particularly childbearing women, they must increase their knowledge and respect of native ways, "learning form the native families". Their role may involve more advocacy and consulting than providing service: roles that will only come about through mutual acceptance, trust and respect.

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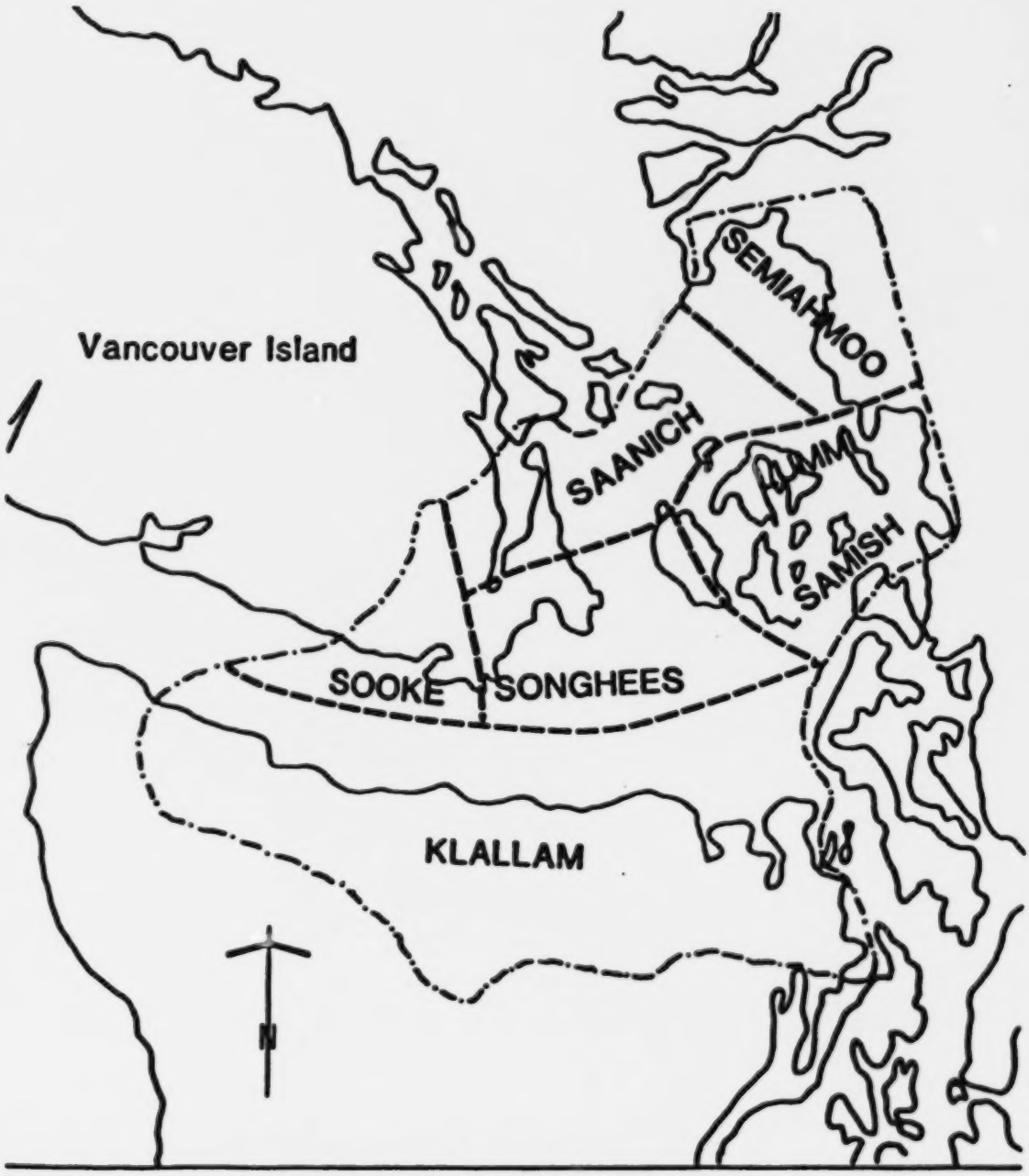
native.txt papers

MAP 1



Straits Salish Ethnic Groups

Adapted from Wilson Duff, "The Fort Victoria Treaties," BC Studies 3(1969),10.

Figure 1

Medicine Wheel: Directions of Understanding

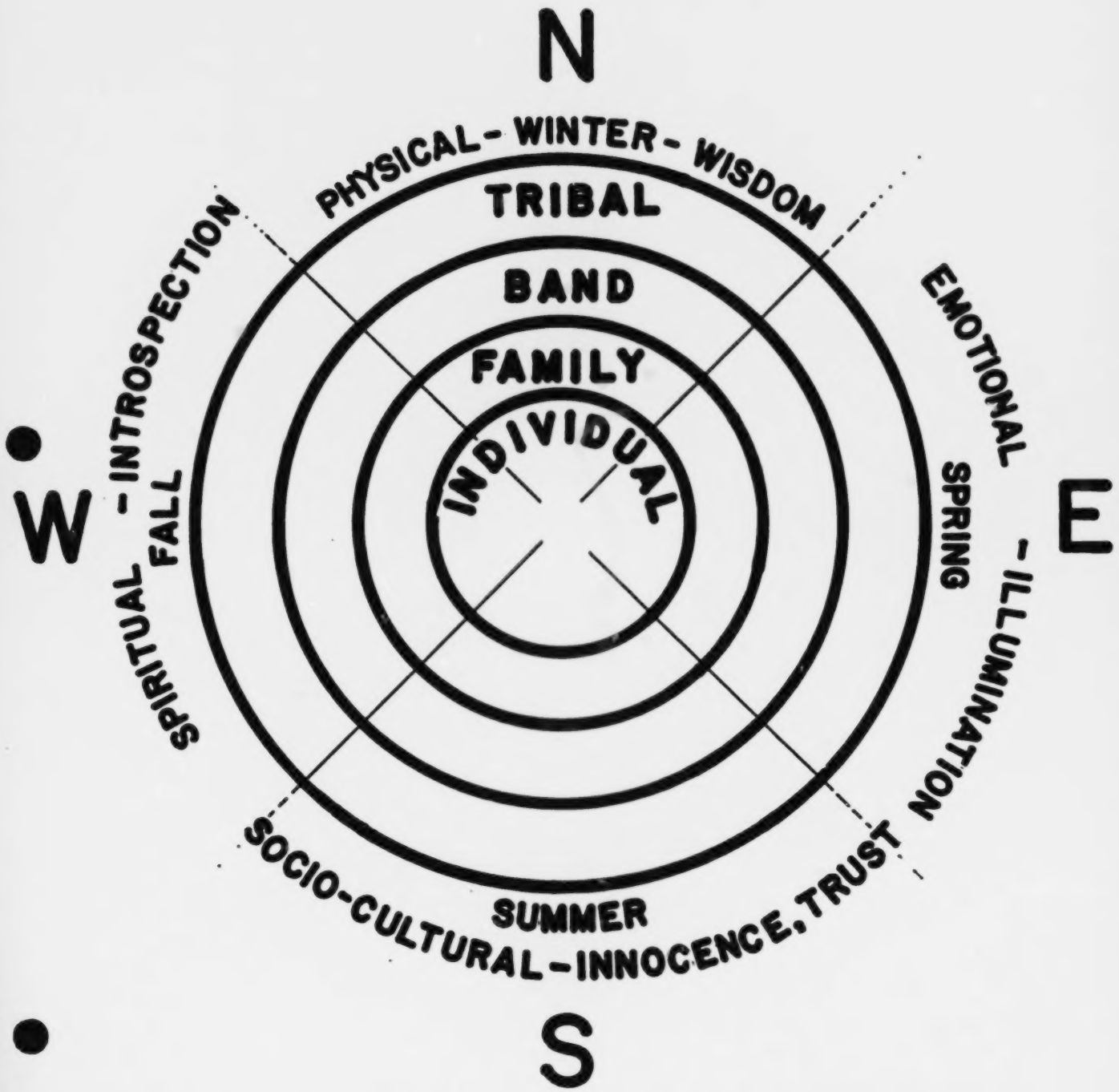


Figure 2

Integrated Medicine Wheels

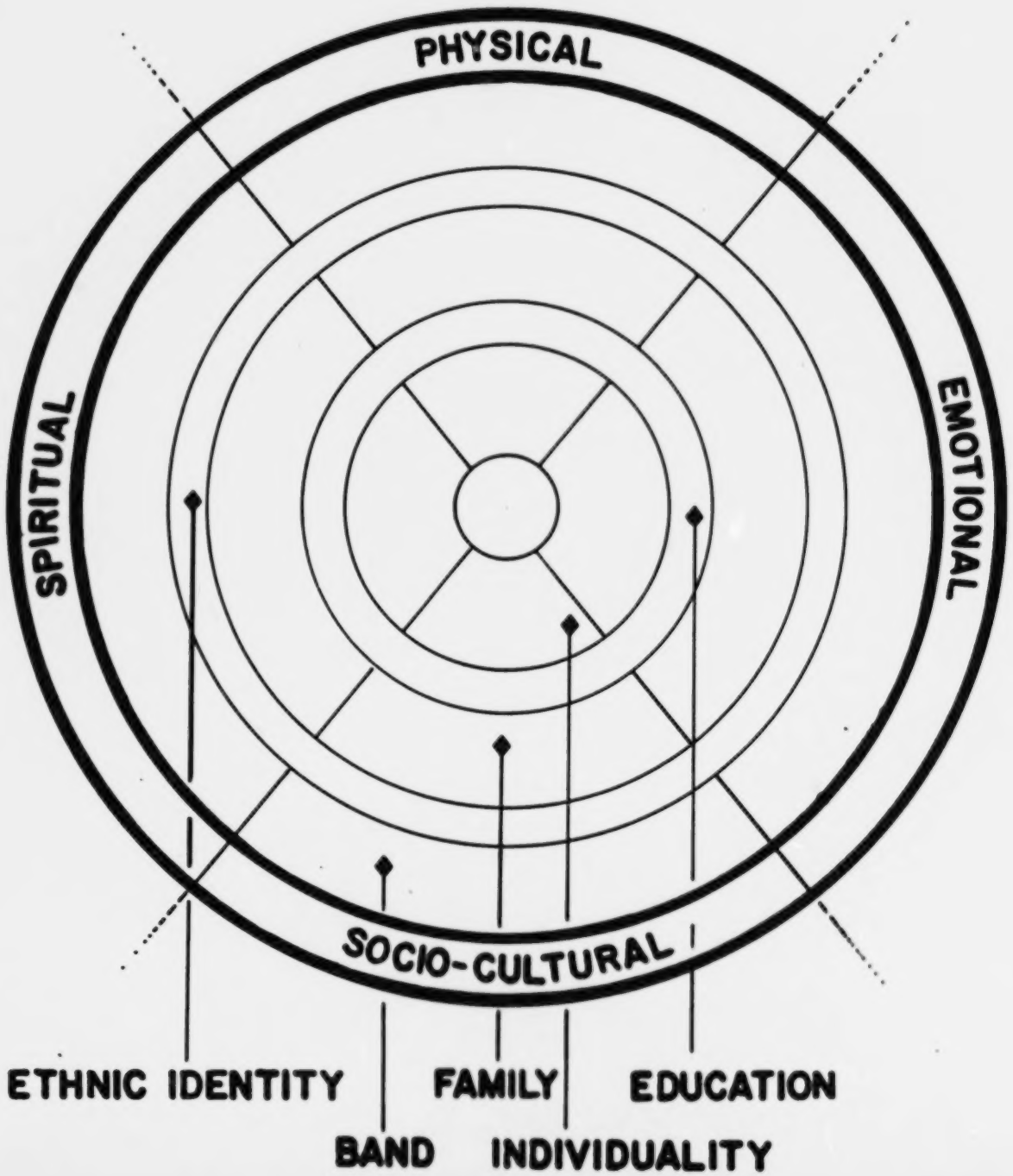


Figure 3
Circle of Life
Coast Salish Perspective

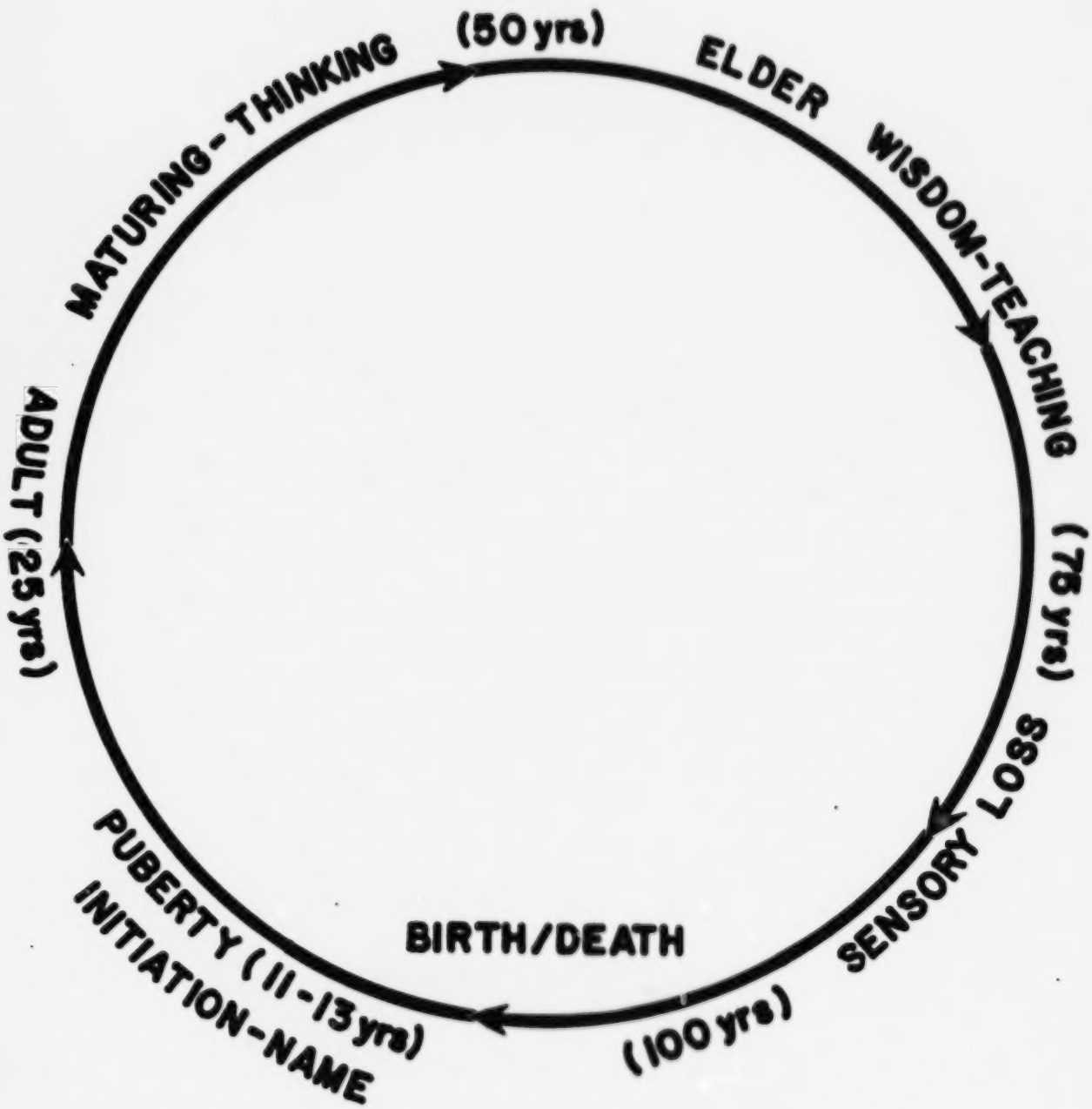


Figure 4
Life Within Medicine Wheels